STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		15E247	B. WINC			06/04/	2013
NAME OF P	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
ST DAIII	. HERMITAGE LLC				7TH AVE GROVE, IN 46107		
					O(OVE,   V +0107		212
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
F000000		,					
	This visit was f	or a Recertification and	F000	0000			
	State Licensur	e Survey.					
	-	May 28, 29, 30, 31, &					
	June 3, & 4, 20	)13					
	Facility Number						
	Provider Numbe						
	AIM Number: 1	100274990					
	0						
	Survey team:	. TO					
	Patti Allen, SW						
	Marcy Smith, F						
	Dinah Jones, F	XIV.					
	Census bed ty	ne:					
	NF: 44	рс.					
	Residential: 50	n					
	Total: 94	9					
	Census payor	type:					
	Medicaid: 24	•					
	Other: 70						
	Total: 94						
	Residential sar	mple: 7					
		cies reflect state					
		n accordance with 410					
	IAC 16.2.						
	0116	and the second s					
	-	completed on May 10,					
	ZU13; by Kimb	erly Perigo, RN.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

000391

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/25/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  06/04/2013
NAME OF P	PROVIDER OR SUPPLIER	<b>.</b>	STREET	ADDRESS, CITY, STATE, ZIP CODE	•
ST PAUL	. HERMITAGE LLC			17TH AVE I GROVE, IN 46107	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OVLE11

Facility ID: 000391

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH	DBIG	00	COMPLI	ETED
		15E247	A. BUII			06/04/	2013
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L.					
CT DALII	HERMITAGE LLC				7TH AVE GROVE, IN 46107		
STPAUL	HERIVII I AGE LLC			BEECH	GROVE, IN 40107		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F000280	483.20(d)(3), 483	3.10(k)(2)					
SS=D		ICIPATE PLANNING					
	CARE-REVISE C						
		the right, unless adjudged					
	·	therwise found to be					
	•	der the laws of the State, to					
		nning care and treatment or					
	changes in care a	and treatment.					
	Λ comprehensive	care plan must be					
	•	7 days after the completion					
	•	sive assessment; prepared					
	•	nary team, that includes					
		sician, a registered nurse					
		for the resident, and other					
	appropriate staff i	in disciplines as determined					
	by the resident's	needs, and, to the extent					
	•	articipation of the resident,					
		nily or the resident's legal					
	•	nd periodically reviewed					
	-	team of qualified persons					
	after each assess	sment.	F.0.0	0000			05/04/0010
	_		F00	0280	Resident #41 was interviewed	-	07/04/2013
	Based on reco	rd review and			Social Services about her den	iai	
	interview, the fa	acility failed to ensure			needs on 5/31/2013. Social		
	care plan interv	ventions were revised			Services also contacted POA resident #41 and discussed	וכ	
	for a resident w	vho indicated her			resident #41's dental concerns	,	
		causing her gums to			Social Services received POA		
		of 2 residents who met			consent to have resident #41	_	
					seen by facility dentist and PO	Α	
		review of dental			signed dental consent form. U		
	services in a sa	•			Manager and Social Services		
	(Residents #41	)			made arrangements for		
					facility-contracted dentist to		
	Findings includ	le:			provide an emergency dental		
	-				exam on 6/4/2013. Resident #	41	
	The clinical rec	ord of Resident #41			was seen on 6/4/14 and her		
		on 5/31/13 at 11:45			dentures were filed down to	e all	
		511 5/5 1/ 15 at 11.45			provide a better fit. Dr. Craig E DDS completed a progress	all,	
	a.m.				note. At the time of admission,	,	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPL	ETED
		15E247	- 1	LDING		06/04/	2013
		1 -	B. WIN		A DDDDGG CUTY CTATE TID CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
OT DAI!!					I7TH AVE		
STPAUL	. HERMITAGE LLC			BEECH	I GROVE, IN 46107		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Diagnoses for	Resident #41 included,			each resident/family		
	but were not li	mited to depression			representative will choose a		
		wallowing. The			dental provider - either the		
	1	dmitted to the facility			facility-contracted provider or	one	
	on 3/26/12.	difficulty to the facility			of their choice.All dental care plans will be reviewed by the		
	011 3/20/12.				MDS coordinator/RN and Soc	rial	
	A	oimer Data			Services to ensure that all		
	A quarterly Mir				residents that have been		
		ated 4/30/13, indicated			identified a having a need for		
	Resident #41 \	was moderately			dental care have been connec	cted	
	impaired in he	r decision-making			with that service. All residents	;	
	ability.				that are found to be in need o		
					dental services will be schedu		
	A care plan for	Resident #41 dated			for an exam.All resident chart	S	
	-	dated 4/29/13, indicated			will be reviewed by Social Services to ensure that annual	N.	
	· ·	[name of resident] has			dental exams have been	11	
	-	<del>-</del>			completed for each resident.	Δ	
	1	er dentures. She			dental tracker form will be cre		
		nce with her oral			and maintained in the social		
		e Goal was "[name of			service section of the chart.Al	I	
	Resident] will I	nave an oral mucosa			residents' annual dental exam	ns	
	that is moist, p	ink and intact on a			will be scheduled with their		
	daily, on-going	basis" Interventions			chosen provider.SSD and MI		
	included "Conf	inue to monitor the			coordinator will hold an in-ser		
	areas [name o	f Residentl is			to review the process of notify social services and MDS	/ing	
	_	in her mouth. If she			coordinator of dental complain	nte	
		ave discomfort have			SSD will notify families/POA of		
					dental needs and appointmen		
	_	dent] seen by the			will be scheduled as appropria		
		et an order from the			MDS coordinator will update of	care	
	I	sess oral cavity for			plan.If the resident or family		
	presence ofi	nflamed gums"			member does not wish to rece	eive	
					suggested treatment for an		
	An "Oral Healt	h" assessment dated			identified concern, a declination		
	4/30/13, perfor	med by the Minimum			of services form will be signed the family/POA., and staff will		
		S) Coordinator,			continue to monitor the condit		
	-	dent #41 had upper			routinely with MDS assessme		
		• •			utilizing the oral health form		
	l aug iower gen	tures and had mouth			Lambard and order router form		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII I	DING	00	COMPL	ETED
		15E247	A. BUILI B. WING			06/04/	/2013
			b. WING	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	ER			7TH AVE		
ST PALII	HERMITAGE LLO	3			GROVE, IN 46107		
	,						
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	-	TAG			DATE
	1 ·	as relieved by taking out			unless there is a change of condition.The MDS		
	•	e. The resident			coordinator/nurse on admission	nn	
		ne MDS coordinator in			comprehensive assessment,	511	
	this assessme	ent her dentures were			quarterly assessments and		
	rubbing a sore	e on the right side of her			annual assessments will		
	mouth. A "Co	mments/Action" section			complete an oral health form.		
	of this assess	ment indicated "Plan			This form will be reviewed	.4	
	Continue to m	nonitor areas on rt [right]			quarterly in QA.MDS coording will complete a Social Service		
	and side of gu				Referral form any time a care		
					plan indicates a resident has		
	During an inte	erview with Resident #41			need for a dental exam.Socia		
	_	10:52 a.m., she			Services will ask all residents		
		metimes my gums are			during their admission		
		e my lower plate out and			comprehensive assessment,		
		e my lower plate out and			quarterly assessment and the annual assessment if they ne		
	eat soup."				to be seen by the dentist. If the		
					resident identifies a need,		
	_	erview with the Social			services will be coordinated a	s	
		tor on 6/3/13 at 8:40			appropriate.		
		cated she had spoken to					
		on 5/31/13 and the					
	resident told h	ner she was having a					
	problem with t	the lower dentures					
	rubbing on he	r gums, making them					
	sore. The Soc	cial Service Director					
	indicated at th	at time that she had					
	also interview	ed a Certified Nursing					
		A) on the evening shift,					
	,	indicated Resident #41					
	•	the CNA) she wanted					
	,	tures out because they					
		and she would just eat					
		er. The Social Service					
		ated, during this					
		3/3/13, if a resident					
	complains to a	a staff member about a					

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED	
		15E247	B. WIN			06/04/2	2013
			D. (VII)		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	₹		1	7TH AVE		
ST PAUL	. HERMITAGE LLC				GROVE, IN 46107		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	n, the staff member a "Social Service					
		and give it to her. She					
		ange for the resident to					
	receive dental						
		did not receive a					
		r Resident #41 for					
	dental services	S.					
	During an inter	view with the MDS					
		1 5/31/13 at 2:15 p.m.,					
		tion was requested					
		ated and/or revised					
	1	ventions for Resident					
		ns. On 5/31/13 at 2:30					
	l ·	Coordinator indicated					
		ole to find any further					
		ne indicated she did not					
	1	e had not been a					
	revision.						
	3.1-35(d)(2)(B)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OVLE11

Facility ID: 000391

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH	DDIC	00	COMPL	ETED
		15E247	A. BUILDING B. WING  06/04/2013			2013	
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
OT DALII	LIEDMITAGELLO				7TH AVE		
STPAUL	HERMITAGE LLC		BEECH		GROVE, IN 46107		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	_	DATE
F000282 SS=D	CARE PLAN The services proving facility must be proving the provin		F00	0282	Resident #41 was interviewed Social Services about her den needs on 5/31/2013. Social	tal	07/04/2013
	interview, the facare plan interview implemented for indicated her dher gums to be residents who	acility failed to ensure ventions were or a resident who entures were causing sore, for 1 of 2 met the criteria for al services in a sample ats #41)			Services also contacted POA oresident #41 and discussed resident #41's dental concerns Social Services received POA' consent to have resident #41 seen by facility dentist and PO signed dental consent form. Underside the Manager and Social Services made arrangements for facility-contracted dentist to provide an emergency dental exam on 6/4/2013. Resident #	s. s A nit	
	was reviewed of a.m.  Diagnoses for I but were not lin and difficulty sy	rord of Resident #41 on 5/31/13 at 11:45 Resident #41 included, nited to depression wallowing. The dmitted to the facility			was seen on 6/4/14 and her dentures were filed down to provide a better fit. Dr. Craig B DDS completed a progress no At the time of admission, each resident/family representative choose a dental provider - eith the facility-contracted provider one of their choice. All dental oplans will be reviewed by the MDS coordinator/RN and Soci Services to ensure that all	te. will er or care	
	A quarterly Min Assessment da Resident #41 v	ated 4/40/13, indicated			residents that have been identified a having a need for dental care have been connec with that service. All residents that are found to be in need of dental services will be schedul for an exam. All resident chart will be reviewed by Social	ed	

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Event ID: OVLE11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) N	IULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIT	ILDING	00	COMPLETED
		15E247	B. WI			06/04/2013
		l	D. WII		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	L Comment		1	7TH AVE	
OT DALII	LIEDMITACELLO					
SIPAUL	HERMITAGE LLC			BEECH	GROVE, IN 46107	
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
					Services to ensure that annua	d
	A care plan for	Resident #41 dated			dental exams have been	
	1/3/13 and updated 4/29/13, indicated				completed for each resident. A	4
	· ·				dental tracker form will be crea	ated
	-	name of resident] has			and maintained in the social	
	upper and lowe	er dentures. She			service section of the chart. A	
	needs assistan	ice with her oral			residents' annual dental exam	S
	hvaiene" The	Goal was "[name of			will be scheduled with their	
		nave an oral mucosa			chosen provider. SSD and MI	
	_				coordinator will hold an in-serv	
	-	ink and intact on a			to review the process of notify	ing
		basis" Interventions			social services and MDS	
	included "Conti	inue to monitor the			coordinator of dental complain	
	areas [name of	f Resident] is			SSD will notify families/POA o	
	complaining of	in her mouth. If she			dental needs and appointmen	
		ave discomfort have			will be scheduled as appropria MDS coordinator will update of	
					plan. If the resident or family	ale
	_	lent] seen by the			member does not wish to rece	avive
		et an order from the			suggested treatment for an	,,,,,
		sess oral cavity for			identified concern, a declination	on
	presence ofir	nflamed gums"			of services form will be signed	
					the family/POA., and staff will	,
	An "Oral Health	n" assessment, dated			continue to monitor the conditi	ion
		med by the Minimum			routinely with MDS assessme	nt
	•	•			utilizing the oral health form	
	Data Set (MDS				unless there is a change of	
		dent #41 had upper			condition. The MDS	
	and lower dent	ures and had mouth			coordinator/nurse on admission	on
	pain which was	s relieved by taking out			comprehensive assessment,	
	her lower plate	. The resident			quarterly assessments and	
	•	MDS coordinator in			annual assessments will	
		nt her dentures were			complete an oral health form.	
		on the right side of her			This form will be reviewed quarterly in QA. MDS coordinates	ator
	•	•			will complete a Social Service	
		nments/Action" section			Referral form any time a care	
	of this assessm	nent indicated "Plan			plan indicates a resident has a	,
	Continue to mo	onitor areas on rt [right]			need for a dental exam. Socia	
	and side of gur	n area."			Services will ask all residents	
					during their admission	
	During an inter	view with Pesident #41			comprehensive assessment,	
	During an inter	view with Resident #41				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15E247	B. WIN	IG		06/04/	/2013
NAME OF I	PROVIDER OR SUPPLIEI		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	ROVIDER OR SULLEIE			501 N 1	7TH AVE		
ST PAUL	HERMITAGE LLC			BEECH	GROVE, IN 46107		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		10:52 a.m., she			quarterly assessment and the	1	
	indicated, "Sor	netimes my gums are			annual assessment if they need to be seen by the dentist. If the		
	sore so I leave	my lower plate out and			resident identifies a need,	-	
	eat soup."				services will be coordinated as	3	
					appropriate.		
	There was no	documentation in					
	Resident #41's	s clinical record which					
	indicated anyo	ne had assessed her					
	mouth or refer	red her for dental					
	services between	en 4/30/13 and					
	5/31/13, as inc	licated by the care					
	plan.						
	During an inter	view with the Social					
	Service Directo	or on 6/3/13 at 8:40					
	a.m., she indic	ated she had spoken to					
	Resident #41 of	on 5/31/13 and the					
	resident told he	er she was having a					
	problem with the	ne lower dentures					
	rubbing on her	gums, making them					
	sore. The Soci	al Service Director					
	indicated at the	at time that she had					
	also interviewe	ed a Certified Nursing					
	Assistant (CNA	A) on the evening shift,					
	5/31/13, who ii	ndicated Resident #41					
	had told her (th	ne CNA) she wanted					
	her lower dent	ures out because they					
	were hurting a	nd she would just eat					
	soup for dinne	r. The Social Service					
	Director indica	ted, during this					
	interview on 6/	3/13, if a resident					
	complains to a	staff member about a					
		n, the staff member					
		"Social Service					
	Referral Form'	and give it to her. She					

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Facility ID: 000391

If continuation sheet

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/25/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:  15E247	A. BUIL B. WINC	DING	00	COMPL 06/04/	ETED
	PROVIDER OR SUPPLIER  HERMITAGE LLC		501 N 1	DDRESS, CITY, STATE, ZIP CODE 7TH AVE GROVE, IN 46107		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	would then arrange for the resident to receive dental services. She indicated she did not receive a referral form for Resident #41 for dental services.  During an interview with the MDS Coordinator on 5/31/13 at 2:15 p.m., further information was requested regarding follow up of her updated plan of care on 4/30/13 regarding Resident #41's sore gums. On 5/31/13 at 2:30 p.m., the MDS Coordinator indicated she was not able to find any further information and she did not know why there had been no follow up.  3.1-35(g)(2)					

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Event ID: OVLE11

Facility ID: 000391

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	ETED
		15E247	B. WIN		<del></del>	06/04/	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				7TH AVE		
ST PALII	HERMITAGE LLC				GROVE, IN 46107		
					GROVE, IIV 10107	-	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F000412 SS=D	483.55(b) ROUTINE/EMER SERVICES IN NF The nursing facilit from an outside re with §483.75(h) o extent covered ur emergency denta needs of each res assist the residen and by arranging from the dentist's refer residents wir dentures to a den  Based on recor interview, the fa dental services provided for res of loose dentur for 1 of 2 reside criteria for revie a sample of 26  Findings includ  The clinical rec was reviewed of a.m.  Diagnoses for I but were not lin and difficulty sy	description of the second of the source of this part, routine (to the noder the State plan); and all services to meet the sident; must, if necessary, at in making appointments; for transportation to and office; and must promptly the lost or damaged whist.  Indicate the state plan of the sident o	F00	TAG  0412	Resident #41 was interviewed Social Services about her denineeds on 5/31/13. Social Services also contacted POA cresident #41 and discussed resident #41 and discussed resident #41's dental concerns Social Services received POA' consent to have resident #41 seen by facility dentist and PO signed dental consent form. Un Manager and Social Services made arrangements for facility-contracted dentist to provide an emergency dental exam on 6/4/2013. Resident # was seen on 6/4/2013 and her lower dentures were filed down provide a better fit. Dr. Craig B DDS. completed a progress note. Social Services, MDS coordinator and Unit Secretary will work with facility-contracted dental facility to create an emergency dental plan and	by tal of s. A nit n to sall,	07/04/2013
	on 3/26/12.  A quarterly Min	imum Data			create a quarterly schedule of dental visits.MDS coordinator/nursing staff will no SSD through Social Service		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	
		15E247	B. WIN	IG		06/04/20	013
NAME OF P	ROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP CODE		
					7TH AVE		
ST PAUL	. HERMITAGE LLC			BEECH	GROVE, IN 46107		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE (	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Assessment da	ated 4/30/13, indicated			referral form of residents need	_	
	Resident #41 v	vas moderately			dental services.SSD will follow with resident and POA. SSD		
	impaired in her	decision-making			help schedule dental	WIII	
	ability.				appointments and arrange		
					transportation as needed to		
	An "Oral Healtl	h" assessment dated			ensure that emergency denta		
	4/30/13, perfor	med by the Minimum			care be provided.Social Servi will maintain a record of annu		
	Data Set (MDS	S) Coordinator,			dental exams in the social se		
	indicated Resid	dent #41 had upper			section of the resident's chart		
	and lower dent	cures and had mouth					
	pain which was	s relieved by taking out					
	her lower plate	. The resident					
	indicated to the	e MDS coordinator in					
	this assessmer	nt her dentures were					
	rubbing a sore	on the right side of her					
	_	mments/Action" section					
	of this assessn	nent indicated "Plan					
	Continue to mo	onitor areas on rt [right]					
	and side of gur						
	J						
	A care plan for	Resident #41 dated					
	•	lated 4/29/13, indicated					
	· ·	name of resident] has					
	_	er dentures. She					
		nce with her oral					
		Goal was "[name of					
	, , ,	nave an oral mucosa					
	_	ink and intact on a					
	•	basis" Interventions					
		inue to monitor the					
	areas [name of						
	_	in her mouth. If she					
		ave discomfort have					
	_	dent] seen by the					
	pnysician or ge	et an order from the					

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STATEMENT OF DEFICIENCIES				, and the second			(X3) DATE SURVEY	
AND PLAN OF CORRECTION				BUILDING 00			COMPLETED	
	15E247		B. WIN	IG		06/04/	2013	
NAME OF D	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER	s		501 N 1	7TH AVE			
ST PAUL HERMITAGE LLC			BEECH GROVE, IN 46107					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE	
	physicianAssess oral cavity for							
	presence ofinflamed gums"							
	on 5/29/2013 1 indicated "Som	view with Resident #41 0:52 a.m., she letimes my gums are my lower plate out and						
	Resident #41's indicated anyou mouth or referr	documentation in clinical record which ne had assessed her ted her to the dentist 13 and 5/31/13.						
	Coordinator on further informar regarding follow assessment on Resident #41's 5/31/13 at 2:30 Coordinator incable to find any and she did no been no follow complaints of some During an interservice Directors.	view with the MDS 5/31/13 at 2:15 p.m., tion was requested v up of her 4/30/13 regarding sore gums. On p.m., the MDS dicated she was not v further information t know why there had up on Resident #41's core gums on 4/30/13.  view with the Social or on 6/3/13 at 8:40 ated she had spoken to on 5/31/13 and the						
	resident told he problem with th	er she was having a ne lower dentures gums, making them						

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	OF CORRECTION  OF CORRECTION  15E247	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 06/04/2013			
	PROVIDER OR SUPPLIER L HERMITAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPP DEFICIENCY)	LD BE COMPLETION			
	sore. The Social Service Director indicated at that time that she had also interviewed a Certified Nursing Assistant (CNA) on the evening shift, 5/31/13, who indicated Resident #41 had told her (the CNA) she wanted her lower dentures out because they were hurting and she would just eat soup for dinner. The Social Service Director indicated, during this interview on 6/3/13, if a resident complains to a staff member about a dental problem, the staff member should fill out a "Social Service Referral Form" and give it to her. She would then arrange for the resident to receive dental services. She indicated she did not receive a referral form for Resident #41 for dental services.  She indicated at that time, the dentist would be seeing Resident #41 on 6/4/31. She also indicated she had done an inservice regarding filling out the referral form, when a resident has dental complaints.  3.1-24(a)(3)						

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